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Notice of Independent Medical Review Decision

Reviewer's Report

DATE OF REVIEW: May 6, 2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Cervical medial branch block, right at C4, C5, C6 and C7; and cervical medial branch block, left at C4, C5, C6 and C7, one week after right-sided injection.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

M.D., Board Certified in Physical Medicine and Rehabilitation and Pain Medicine.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

The requested cervical medial branch block, right at C4, C5, C6 and C7; and cervical medial branch block, left at C4, C5, C6 and C7, one week after right-sided injection is not medically necessary.

PATIENT CLINICAL HISTORY [SUMMARY]:

The patient is a male who reported a work-related injury on xx/xx/xx. According to the documentation submitted for review, the patient underwent magnetic resonance imaging (MRI) of the cervical spine on 6/3/13 which revealed a 2.5 mm concentric disc bulge at C6-7 combined with mild dorsal ligamentous hypertrophy resulting in narrowing of the spinal canal to a mid-sagittal diameter of 8 mm and a mild narrowing of the bilateral neural foramina. The patient was

seen on follow-up on 1/6/15. The documentation indicated that the patient had been treated with medications, physical therapy, and trigger point injections and was working full-time. The patient was noted to have a significant amount of facet based pain. The request was made for medial branch blocks. The physical examination revealed the range of motion was decreased with extension and side bending. The patient had a negative Spurling's maneuver and had tenderness to palpation in the spinous processes. The deep tendon reflexes were +2/4 in the upper and lower extremities. Manual muscle testing was 5/5. The sensation was decreased in a cape-like distribution in the cervical spine and into the proximal upper extremities which the provider opined was consistent with cervical facet syndrome. Manual muscle testing was 5/5. The range of motion of the left shoulder was improved with a negative provocative testing at the left shoulder. The surgical history included cervical spine and left shoulder injury on xx and left shoulder arthroscopy performed 6/29/14. The treatment plan was to continue to work full duty with a home exercise program, continue with Ultram up to four times per day and medial branch blocks at C4, C5, C6, and C7 right-sided and then left.

The URA indicated that the patient did not meet Official Disability Guidelines (ODG) criteria for the requested services. Per the denial letter dated 3/26/15, the URA indicates that there are not specifics in terms of type and extent of past physical therapy in terms of cervical spine in conjunction with conversion to a daily home exercise program to maximize the approach to physical methods of treatment to cervical spine.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The Official Disability Guidelines (ODG) indicates that facet joint radiofrequency neurotomies (medial branch blocks) are under study and that diagnostic blocks are recommended prior to a medial branch block. The criteria for a diagnostic block include axial neck pain with no radiation or radiation rarely past the shoulders, tenderness to palpation in the paravertebral areas over the facet region, decreased range of motion with extension and rotation, and the absence of radicular and/or neurologic findings. The approval of a radiofrequency neurotomy includes that there should be evidence of an adequate diagnostic block with a response of more than 70% lasting for the duration of the anesthetic. It is limited to cervical pain that is non-radicular and at no more than two levels bilaterally. There should be documentation of a failure of conservative treatment, including home exercise, physical therapy, and non-steroidal anti-inflammatory drugs (NSAIDs) prior to the procedure for at least four to six weeks. The clinical documentation submitted for review indicates the patient has decreased sensation in a cape-like distribution in the cervical spine and into the proximal upper shoulders and the deep tendon reflexes are +2/4 in the bilateral upper and lower extremities. Manual muscle testing was within normal limits. The Spurling's maneuver was negative. Range of motion of the cervical spine was decreased with extension and side bending. The documentation indicated the patient had conservative care, including medications, physical therapy, and trigger point injections. However, the duration of conservative care was not provided. In the absence of the duration of conservative care, the medical necessity for the requested services has not been established. In accordance with the above, I have determined that the requested cervical medial branch block, right at C4, C5, C6 and C7; and cervical medial branch block, left at C4, C5, C6 and C7, one week after right-sided injection is not medically necessary for treatment of the patient's medical condition.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☐ MEDICAL JUDGMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)